



**DEFENSE CENTERS OF EXCELLENCE**  
For Psychological Health & Traumatic Brain Injury

**Today's webinar is:**

**Traumatic Brain Injury 101:  
Screening and Assessment Methodology**

**Aug. 15, 2013, 1-2:30 p.m. (EDT)**

**Presenter: Sherray Holland, PA-C**  
TBI Clinical Educator

Contractor, Defense and Veterans Brain Injury Center

**Moderator: Lt. Cmdr. Cathleen Shields, MS, CCC-SLP/CBIS, USPHS**  
Acting Director of Education  
Defense and Veterans Brain Injury Center



# Webinar Details

- Live closed captioning is available through federal relay conference captioning (see the “Closed Captioning” pod)
- Webinar audio is **not** provided through Adobe Connect or Defense Connect Online
  - Dial: **888-455-0936**
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- Webinar information
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- Question-and-answer session
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# Continuing Education Details

- DCoE's awarding of CE credit is limited in scope to health care providers who actively provide psychological health and traumatic brain injury care to active-duty U.S. service members, reservists, National Guardsmen, military veterans and/or their families.
- The authority for training of contractors is at the discretion of the chief contracting official. Currently, only those contractors with scope of work or with commensurate contract language are permitted in this training.

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- The following CE credit is approved for this activity:
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- Webinar pre-registration is **required** to receive CE credit

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If you pre-registered for this webinar and want to obtain a CE certificate, you must complete the online CE evaluation.

- If you meet the eligibility requirements and pre-registered on or before **Monday, Aug. 12, 2013**, at 11:59 p.m. (EDT), please visit [conf.swankhealth.com/dcoe](http://conf.swankhealth.com/dcoe) at the conclusion of the webinar to complete the online CE evaluation and download your CE certificate.
- The Swank HealthCare website will open immediately following the webinar and remain open through **Thursday, Aug. 22, 2013**, at 11:59 p.m. (EDT).
- If you did not pre-register, you will not be able to receive CE credit for this event.

# Traumatic Brain Injury 101: Screening and Assessment Methodology

- Traumatic brain injury (TBI) occurs when a sudden trauma or head injury disrupts the function of the brain. TBI is commonly known as the signature wound of the Afghanistan and Iraq conflicts.
- TBI symptoms can appear immediately after or weeks to months following the injury. The mechanism of injury and severity of the injury guide screening, assessment and the plan of care.
- This webinar includes a discussion of typical comorbid occurring conditions that present with mild TBI/concussion and the most current approaches to symptom management of “the big four” (i.e., sleep, cognition, headache and mood).
- The goal of this webinar is to enhance health care providers’ knowledge of TBI and treatment for service members and veterans.

# Presenter



Ms. Sherry Holland

- Ms. Sherry Holland, PA-C, supports DVBIC as the TBI Clinical Educator at DVBIC headquarters in Rockville, Md.
- Received a Bachelor of Science Physician Assistant (PA) degree and Certificate in Primary Care from Howard University in Washington, D.C., in 2004
- Board certified as a PA through the National Commission of Certification of Physician Assistants and the Maryland Board of Physicians
- Supports numerous projects within DVBIC's Education Division and the Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury, including serving as lead content developer for Brainline Military online civilian provider courses and contributions to the development of patient and provider education tools
- Actively involved with the American Academy of Physician Assistants and has collaborated with their staff on military families and veterans initiatives

# Traumatic Brain Injury 101

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**Sherray Holland, PA-C**

TBI Clinical Educator

Contractor, DVBIC



# Disclaimer

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The views expressed in this presentation are those of the presenter and do not reflect the official policy of the Defense Department or U.S. Government. This presenter has no financial interests to disclose.

# Learning Objectives

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This webinar will:

- Review TBI, mechanism of injury and Defense Department diagnostic criteria for mild, moderate, severe and penetrating TBI
- Explain and describe how military TBI presents in various clinical practice settings
- Compare and contrast the components of a TBI versus posttraumatic stress disorder (PTSD)
- Describe screening and assessment methods and challenges when identifying patients with TBI

# Traumatic Brain Injury 101

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## What is Traumatic Brain Injury (TBI)?

# Concussion/mTBI Definition

- Two conditions must be met to suspect/diagnose a concussion:
  - A traumatic injury mechanism/event must occur (e.g., motor vehicle crash [MVC], fall, sports, training accident, blast, etc.)
  - The person must have experienced a *loss* of consciousness (LOC) or an *alteration* of consciousness (AOC)
  - More difficult to determine when injury occurs in combat setting
  - The patient interview is key to making the correct diagnosis
  - Reported AOC requires further investigation
  - Neurological disruption versus psychological reaction

# Defense Department TBI Definition

- Traumatically induced structural injury or physiological disruption of brain function as a result of external force to the head
- New or worsening of at least one of the following clinical signs:
  - Loss of consciousness or decreased consciousness
  - Loss of memory immediately before or after injury
  - Alteration in mental status (confused, disoriented, slow thinking)
  - Neurological deficits
  - Intracranial lesion

# Glasgow Coma Scale

## GCS

**Mild TBI**  
**= 13-15**

**Moderate TBI**  
**= 9-12**

**Severe TBI**  
**= 3-8**

Glasgow Coma Scale		
Motor Response	Obeys commands	6
	Localizing responses to pain	5
	Generalized withdrawal to pain	4
	Flexor posturing to pain	3
	Extensor posturing to pain	2
	No motor response to pain	1
Verbal Response	Oriented	5
	Confused conversation	4
	Inappropriate speech	3
	Incomprehensible speech	2
	No speech	1
Eye Opening Response	Spontaneous eye opening	4
	Eye opening to speech	3
	Eye opening to pain	2
	No eye opening	1

# Severity Rating for TBI

Severity	GCS	AOC	LOC	PTA	Imaging
Mild	13 - 15	≤ 24 hrs	0 - 30 min	≤ 24 hrs	Neg
Moderate	9 - 12	> 24 hrs	> 30min < 24 hrs	> 24hrs < 7 days	Pos or Neg
Severe	3 - 8	> 24hrs	≥ 24 hrs	≥ 7 days	Pos or Neg

- Consider imaging results when determining level of severity
- Positive Imaging = at least a moderate TBI rating
- GCS not as useful given complications of theater setting
- Use of AOC in Defense Department severity rating

# Polling Question #1

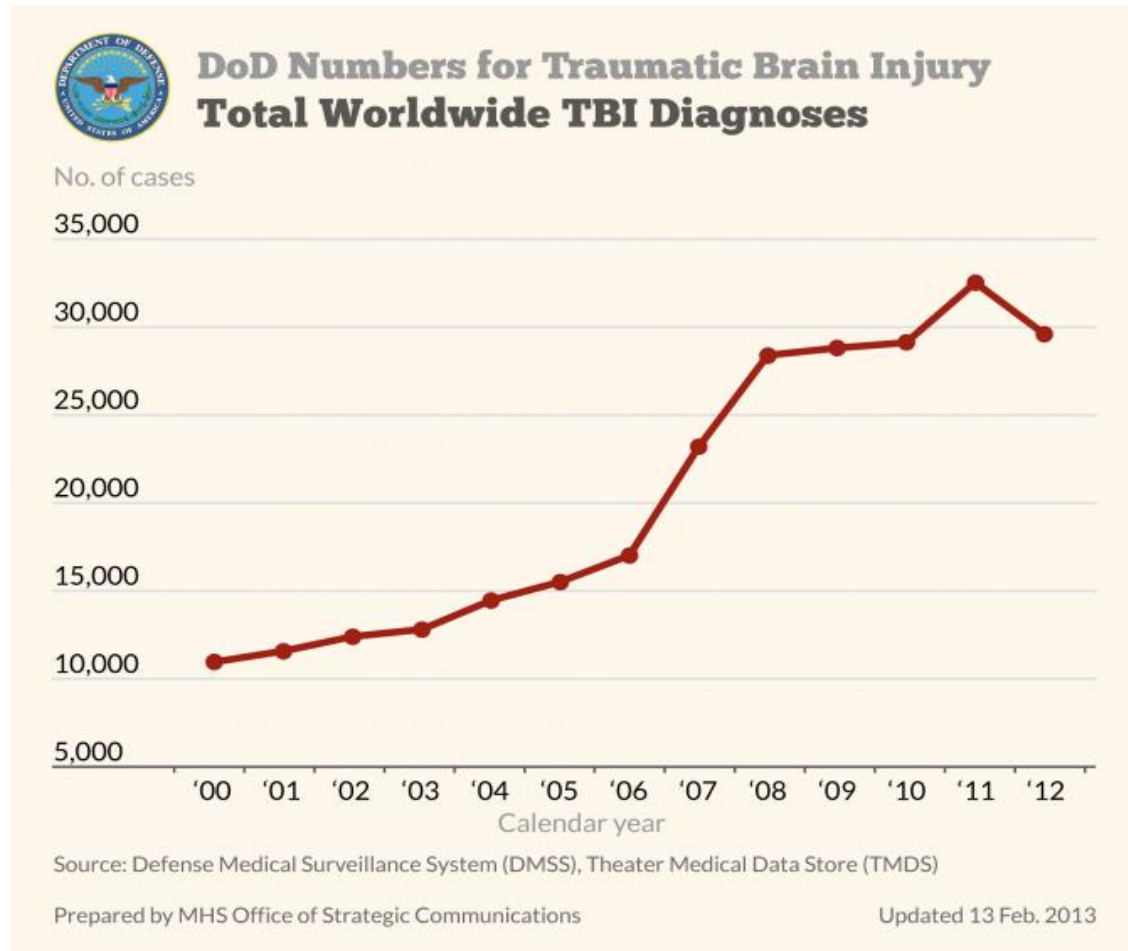
Maj. Holland reports to your emergency room after a motorcycle accident one hour prior. A witness reports he was dazed on the scene with a GCS 13 (M5/V4/E4). Currently he is oriented and his GCS is 15, but reports headaches, dizziness and blurred vision. He has a small scalp laceration. Head computerized tomography (CT) is normal.

At discharge, he will have a diagnosis of:

- A. Mild TBI/mTBI/concussion
- B. Moderate TBI
- C. Severe TBI
- D. Penetrating TBI



# Incidence of TBI by Calendar Year



# TBI By Severity Rating



## DoD Numbers for Traumatic Brain Injury Worldwide – Totals

2000-2013 Q1

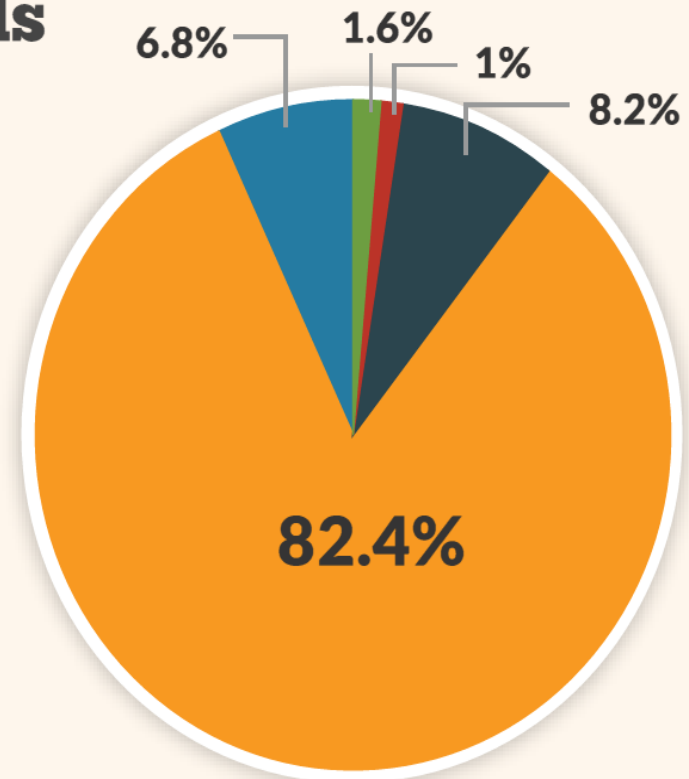
Penetrating	4,275
Severe	2,799
Moderate	22,404
Mild	225,718
Not Classifiable	18,663

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**Total - All Severities**      **273,859**

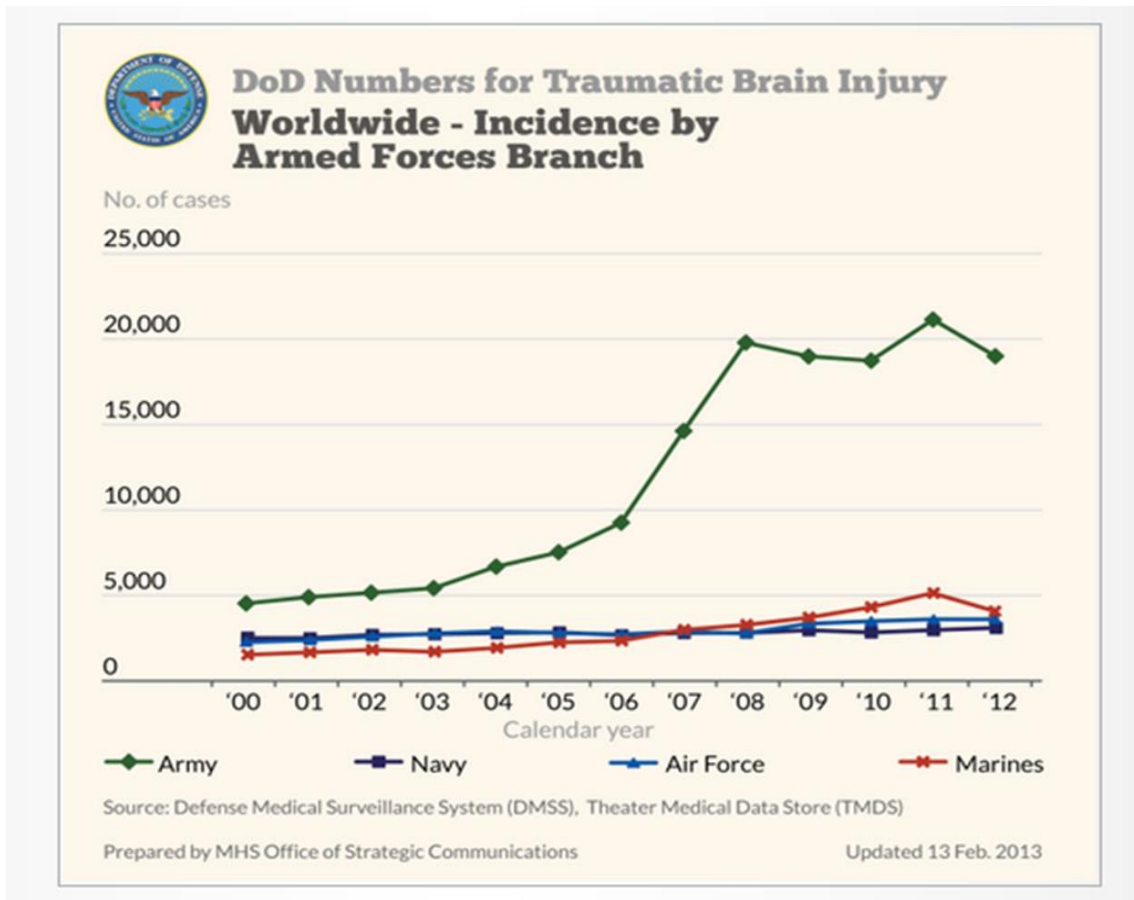
Source: Defense Medical Surveillance System (DMSS),  
Theater Medical Data Store (TMDS)

Prepared by Defense and Veterans Brain Injury Center (DVBIC)



2000-2013 Q1, as of 9 May 2013

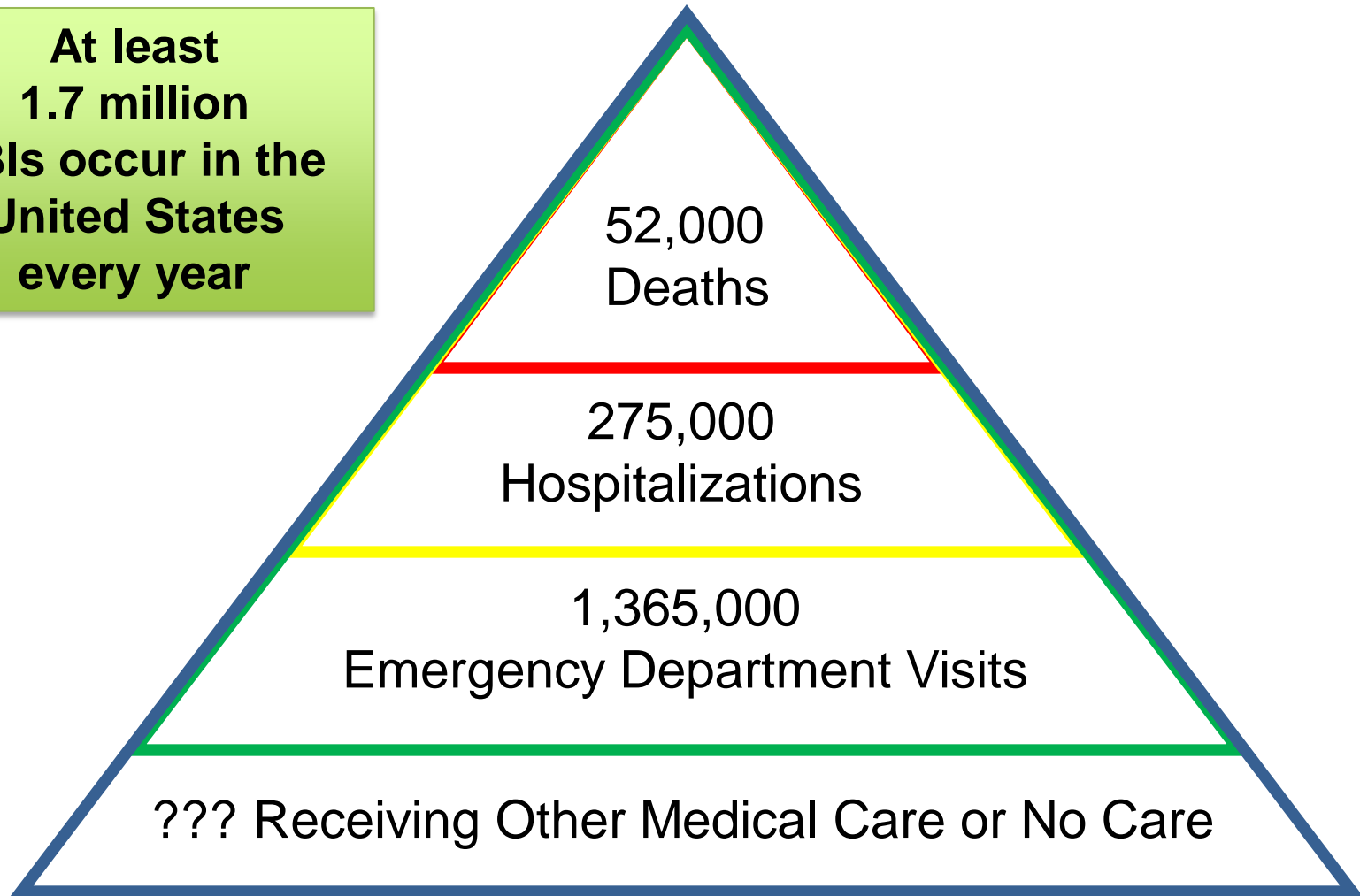
# Incidence by Armed Forces Branch



Numbers reported in this graph represent cases with a reported combat operation of Operation Enduring Freedom/Operational Iraqi Freedom/Operation New Dawn and a U.S. Armed Forces affiliation. Since Coast Guard numbers are small, they are not shown.

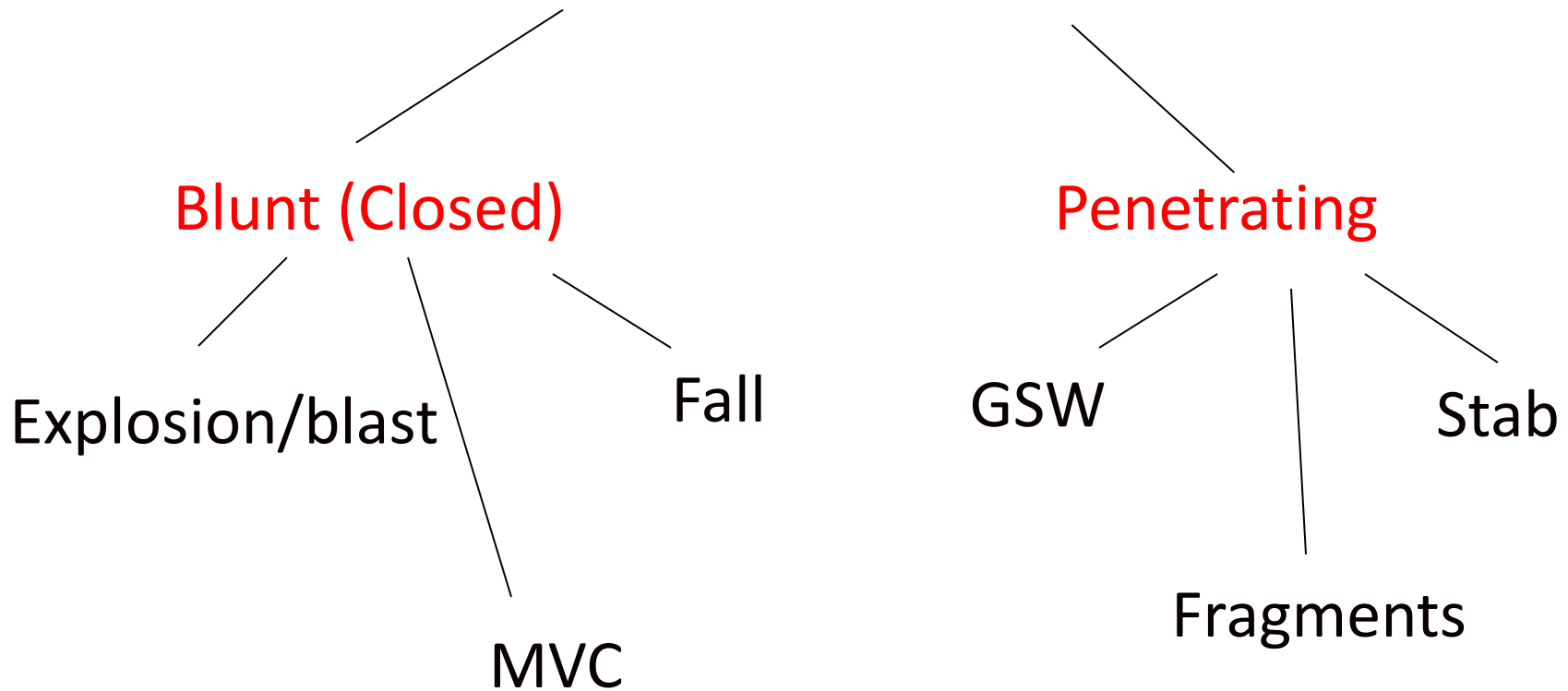
# TBI in the United States

**At least  
1.7 million  
TBIs occur in the  
United States  
every year**



# Mechanisms of Injury

## Traumatic Brain Injury



# Military TBI in the Civilian Setting

- Blast is the most common mechanism of injury in the combat setting.
  - There are four mechanisms of injury. (Blast-related TBIs are likely to have co-existing conditions.)
    - Primary Blast: Atmospheric over-pressure followed by under-pressure or vacuum
    - Secondary Blast: Objects placed in motion (shrapnel)
    - Tertiary Blast: Thrown by the blast wave/wind
    - Quaternary Blast: Other injuries from the blast (i.e., burns and crush injuries)
  - No clear evidence that the types of combat-related concussion are significantly different for blast or blunt trauma from sports physically or on [neuropsychological] testing.

# Military TBI in the Civilian Setting

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- Between 2000 and 2012, greater than 80 percent of TBIs in the military occurred in the non-deployed setting
  - Occasionally service members/veterans are seen initially in a civilian hospital prior to transfer to a military treatment facility or Department of Veterans Affairs (VA) hospital
- Veterans are typically seen years following their injury due to lack of reporting or screening
- The chronicity of their symptoms becomes more complex for providers, and management can be challenging

# Relevance to Civilian Practice

## Homeland Security

Not if, but when:

- Approximately 70 percent of terrorist attacks worldwide involve high explosives
- Terrorist attacks are surprisingly simple and deadly, so terrorists have long viewed vehicle bombs as “[o]ne of the best tools to breach security.”<sup>1</sup>

<sup>1</sup> Warned the Federal Bureau of Investigation and the Department of Homeland Security on July 30, 2004. (US News & World Report, July 2004)



# Relevance to Civilian Practice

## Veterans

- Large participation of reserve and National Guard units in global war on terrorism
- Will eventually return to civilian sector



# Traumatic Brain Injury 101

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## mTBI/Concussion Assessment: Clinical Pearls

# TBI Assessment: Domains to Be Examined

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- History: Incident, mechanism, acute injury characteristics, symptom course
- Symptoms: Cognitive, emotional, physical
- Neurologic exam: Cranial nerves, postural stability, vision
- Neurocognitive function: Attention, concentration, memory
- Psychological function: Depression, anxiety, irritability

# The Interview

- Often helpful to approach the patient in conversation versus repeated questions
- Ask appropriate questions to nail down the entire timeline
  - Get details leading up to, during and after the injury event to identify gaps in memory
- Obtain accurate chronology of symptom onset and progress

# Concussion Assessment: Domains

## History

- Concussion incident – MVC, fall, sports, blast, blunt force trauma
- Mechanisms – MVC (contact, acceleration/deceleration, rotational), fall (coup/contrecoup), blast (primary, secondary, tertiary)
- Acute injury characteristics – LOC/AOC, retrograde amnesia (RA), PTA, headache, dizziness, hearing/vision, nasal/auricular bleeding, poly-trauma/blood loss
- Symptom course – Immediate with gradual improvement over 24 hours, minor symptoms with progressive worsening

# Mild TBI Assessment: Domains

## Symptoms: Systematic inventory

- Interview (acute/subacute; combat setting, local hospital/clinic)
- Tools (subacute/chronic – military treatment facilities/clinic)
  - Neurobehavioral Symptom Inventory (NSI: 22 items)
  - PTSD Checklist (Civilian or Military Version [PCL-C/PCL-M: 17 items])
  - Patient History Questionnaire-9 (PHQ-9: 9+1 items)
  - Drug Abuse Screening Test-20 (DAST-20: 20 items)
  - Dizziness Handicap Inventory (DHI: 25 items)
  - Epworth Sleepiness Scale (ESS: 8 items)

# Mild TBI Assessment: Domains (continued)

- Neurologic Exam

- Focused cranial nerve exam
- Postural stability/vestibular exam (Dix-Hallpike maneuver, Romberg test)
- Visual function (gross acuity, eye movement, binocular function, visual fields, visual inattention)

- Neurocognitive Function

- Mini Mental Status Exam, Military Acute Concussion Evaluation (MACE), Automated Neuropsychological Assessment Metrics (ANAM)
- Full Neuropsychological Evaluation by a specialist

- Psychological Function

- Depression, anxiety, PTSD, suicidality (interview, tools)

# Polling Question #2

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Taking a good patient history includes the following:

- A. Concussion incident
- B. Acute injury characteristics
- C. Symptom course
- D. All of the above



# Potential Consequences of Screening Errors

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- False Positive Errors: Diagnosing someone with a TBI when no TBI occurred
  - Potentially devastating news to the patient
  - Misattribution of symptoms to TBI
  - Incorrect focus of treatment leading to longer lasting symptomology

# Potential Consequences of Screening Errors (continued)

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Causes of false positive screens include:

- Mistaking surprise or shock for AOC
- Not considering significant blood loss
- Not considering onsite sedation
- Diagnosis is based solely on symptom report or cognitive testing results
- Not accurately establishing symptom onset

# Potential Consequences of Screening Errors (continued)

- False Negative Errors: Not identifying a TBI when one has occurred
  - Alienating the patient by incorrectly explaining away symptoms
  - Potentially creating long lasting “post-concussive syndrome” by missing chance for early education and intervention
  - Incorrect focus of treatment leading to longer lasting symptomology

# Potential Consequences of Screening Errors (continued)

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Causes of false negative screens include:

- Not asking enough questions and missing a mTBI/concussion that has occurred in a complex series of events (blast<impact<fall)
- Relying only on a checklist/screening tool
- Lack of overt symptoms taken as lack of injury
- Not performing brain imaging on mTBI/concussion patients and missing greater pathology
- Missing the possibility of an anoxic brain injury

# How to Prevent Misdiagnosis and Missed Diagnoses

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- Do not rely solely on screening checklists
- Perform a thorough records review to obtain injury characteristics
- Interview other injured unit members or contact their unit (if available)
- Talk with the family (personality/intellect)
- Ask about a previous history of TBI
- Do not over/under diagnose based on symptomology

# The Big Four

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## Symptom Management of Sleep, Cognition, Headaches and Mood

# Sleep Disturbances

- 50 percent of patients with TBI have some form of sleep disturbance
- In a study of veterans with TBI, PTSD or chronic pain
  - 93.5 percent of the entire study population had a sleep disorder
  - 65 percent of the population screened positive for mTBI/concussion
- Sleep disturbances may cause harmful consequences on memory function in patients with TBI and/or exacerbate comorbid symptoms
  - May prolong concussion recovery
  - Potentially a risk factor for suicide

# Clinical Assessment – Sleep Dysfunction

## ■ Common Symptoms

- Insomnia
- Excessive daytime somnolence
- Nightmares
- Parasomnias
- Snoring/sleep apnea

## ■ Exam/Clinical Tools

- BMI/body habitus
- Epworth Sleepiness Scale
- Sleep diary



# VA/Defense Department Guidance for Acute Versus Chronic mTBI with Sleep Disturbances

	Management Recommendations <sup>7</sup>
Acute mTBI	<ul style="list-style-type: none"><li>▪ Patient education on mTBI</li><li>▪ Provide information on sleep hygiene</li><li>▪ Advise on the potential effects of medications, caffeine, tobacco and alcohol on sleep</li><li>▪ Prescribe short-term sleep medications such as non-benzodiazepine sleep agents</li></ul>
Chronic mTBI (>3 months)	<ul style="list-style-type: none"><li>▪ Review medications</li><li>▪ Evaluate for comorbid psychiatric conditions</li><li>▪ Provide appropriate pain management</li><li>▪ Conduct sleep study (refer to a specialist)</li><li>▪ Provide training in behavioral techniques to improve quality of sleep</li><li>▪ Implement cognitive behavioral therapy focused on sleep with other behavioral interventions</li></ul>

# Changes in “Executive Functioning”

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- Decreased awareness of thinking changes
- Difficulty planning/setting goals
- Problems being organized
- Difficulty being flexible
- Difficulty problem-solving
- Difficulty prioritizing

# Thinking Changes

- Attention
  - Reduced visual attention
  - Reduced concentration
  - Inability to divide attention between competing tasks
- Processing Speed
  - Slow thinking
  - Slow reading
  - Slow oral and written responses

# Thinking Changes

- Communication
  - Difficulty finding the right words, naming objects
  - Disorganized in communication
- Learning and Memory
  - Information before TBI intact
  - Reduced ability to remember new information
  - Problems with learning new skills

# Clinical Assessment: Thinking Changes

- Neurocognitive assessment is recommended once patient is deemed appropriate for testing and/or based on clinical judgment of the medical team
- If deficits are noted in testing, referral for cognitive rehabilitation therapy (i.e., OT, SLP) typically follows



Photo Courtesy of Jynessa Hockaday

# Post-traumatic Headaches

Cephalgia remains the most common symptom following mTBI/concussion



# Post-traumatic Headache

## Occurrence in mTBI/Concussion

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- The prevalence of chronic daily headaches in returning soldiers after a deployment-related concussion is 20 percent or four to five times higher than that seen in the general U.S. population.
- The headaches resemble chronic migraine and onset is typically within the first week after concussion.

# Acute Versus Chronic Post-traumatic Headache After (PTHA)

- Post-traumatic headaches can be divided into acute and chronic following a mild to severe head injury.
  - Acute: Headache develops within seven days following head trauma or after regaining consciousness following head trauma. The headache resolves within three months.
  - Chronic: Headache develops within seven days following head trauma and persists for greater than three months after the injury.



# Clinical Assessment – PTHA

## History

- When did the headaches begin
- Frequency and duration
- Associated symptoms (i.e., nausea, photophobia, neck pain)
- Alleviating and aggravating factors
- Medications (past and current)
- Diet
- Sleep
- Headache history, if any, prior to TBI

# Clinical Assessment – PTHA (continued)

- MIDAS: The Migraine Disability Assessment Test
- HIT: Headache Impact Test
- Headache Diary

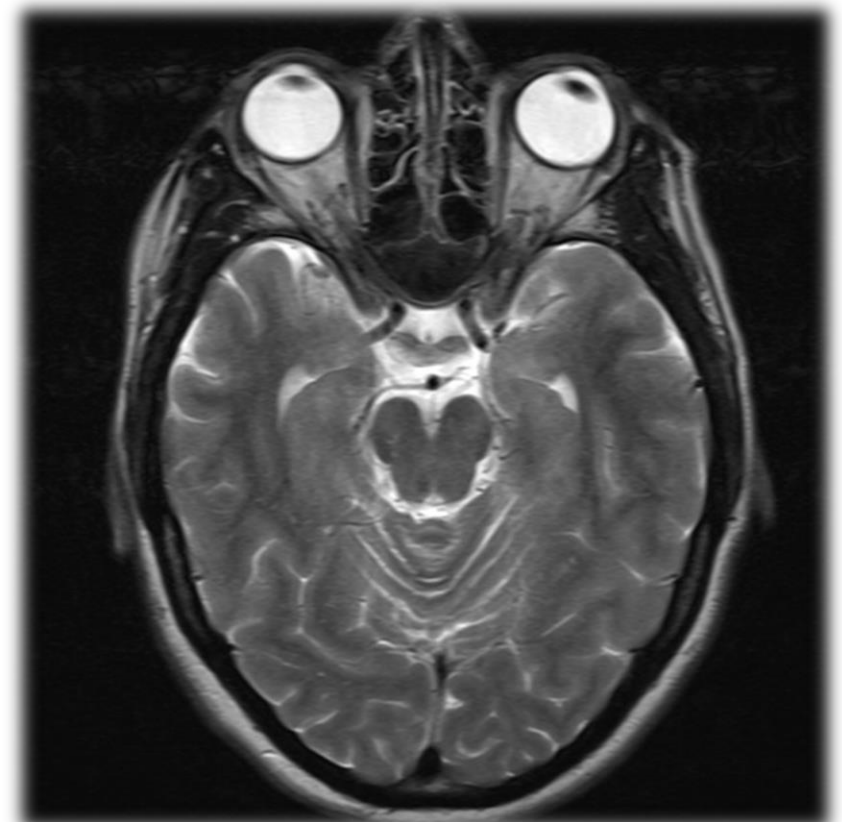


Photo Courtesy of Heather Miller Seger

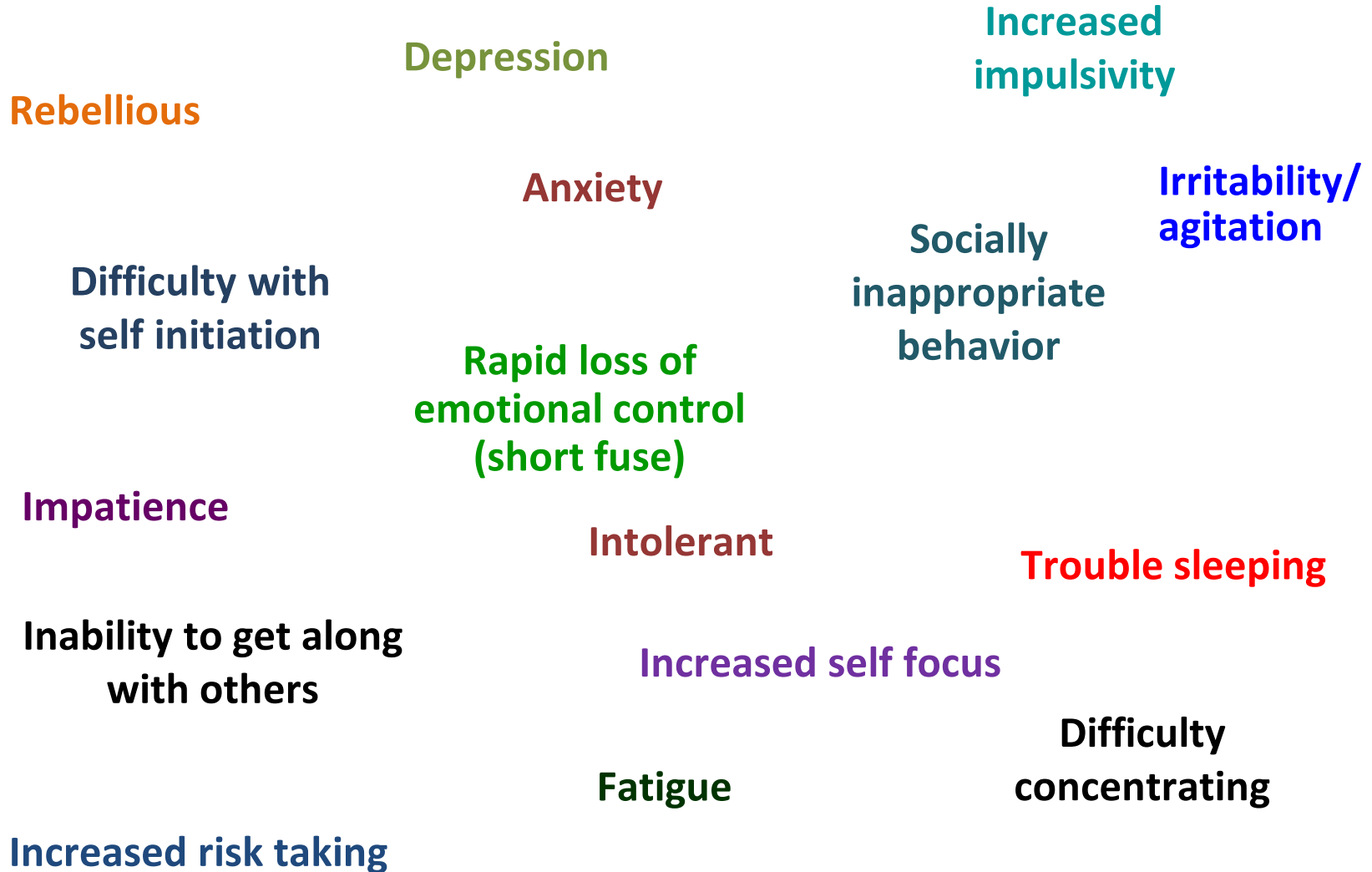
# Pharmacologic Treatment

- Acute Attacks
  - Acetaminophen
  - Nonsteroidal anti-inflammatory drugs (NSAIDs) (do not use first 48 hours after injury)
  - Triptans
- Prophylactic Therapy
  - Tricyclic antidepressants
  - Calcium channel blockers
  - Anticonvulsants
  - Beta blockers

# Nonpharmacologic Therapies

- Trigger and risk factor avoidance
- Proper diet, exercise and sleep hygiene
- Use headache diary
- Biofeedback and stress management
- Cognitive therapy and psychotherapy
- Physical therapy, manipulation, acupuncture, reflexology
- According to S.D. Silberstein, S. Holland, F. Freitag, et al., studies show supplements such as Vitamin B-2, magnesium, feverfew, petasites, melatonin and coenzyme Q10 can be considered

# Emotional, Behavioral and Social Changes



# Emotional, Behavioral and Social Changes (continued)

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Appreciate complex interplay of various factors likely to be involved in expression of symptoms

- Psychological factors (e.g., combat stress, depression, irritability)
- Sleep dysfunction
- Comorbid medical conditions
- Normal readjustment issues related to deployment

# Polling Question #3

Which sign or symptom is related to posttraumatic stress disorder (PTSD) rather than mTBI/concussion?

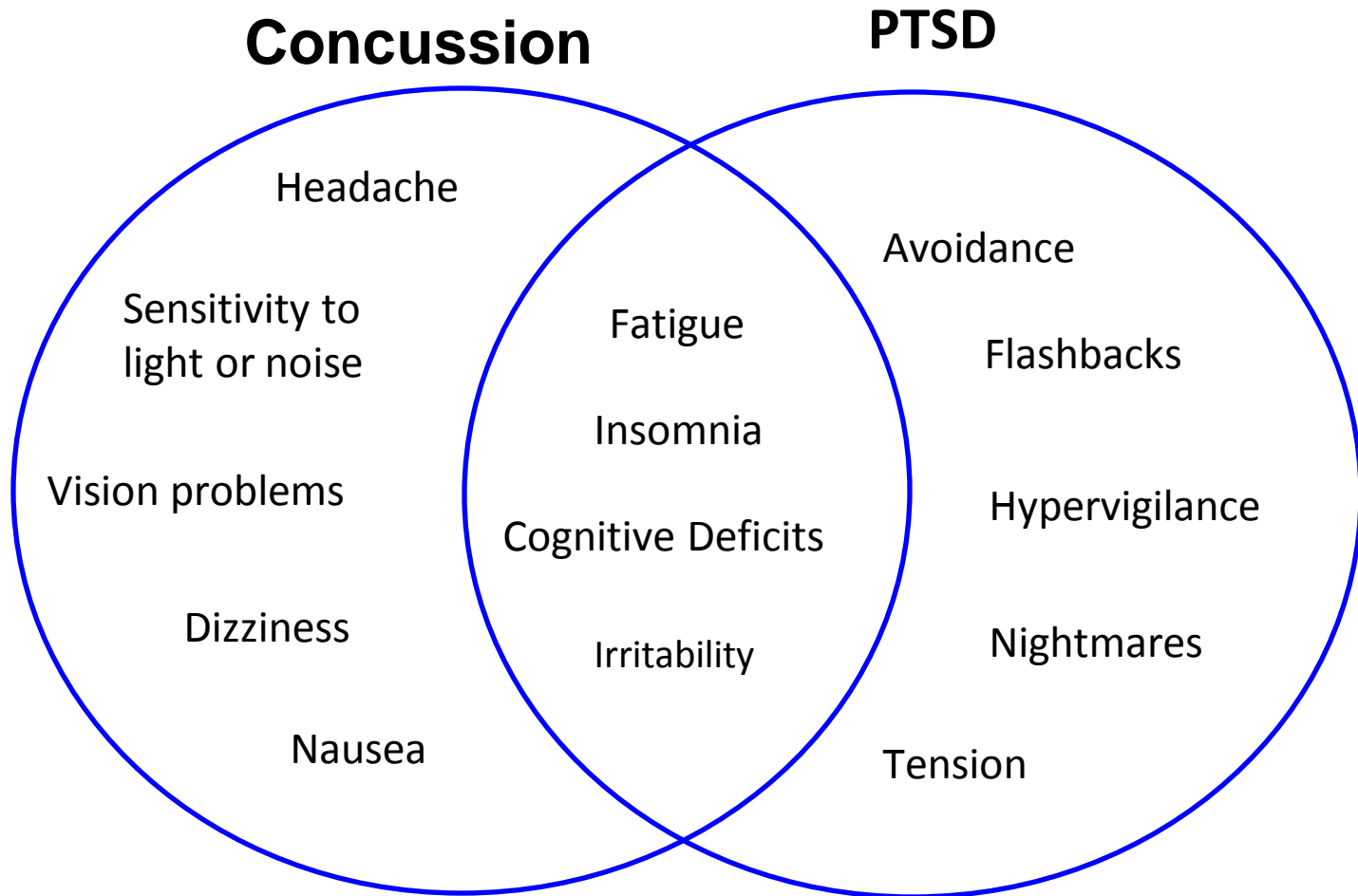
- A. Headache
- B. Dizziness
- C. Avoidance
- D. Sensitivity to noise

# Posttraumatic Stress Disorder

- According to the DSM-5, the diagnostic criteria identifies the trigger as an exposure to actual or threatened death, serious injury or sexual violation and must result from one or more of the following scenarios, in which the individual:
  - Directly experiences the traumatic event
  - Witnesses the traumatic event in person
  - Learns that the traumatic event occurred to a close family member or close friend (with the actual or threatened death being either violent or accidental) or
  - Experiences first-hand repeated or extreme exposure to aversive details of the traumatic event (not through media, pictures, television or movies unless work-related)



# Concussion and PTSD Overlap



# Treatment – PTSD and TBI

- Veterans with a history of TBI may necessitate a shift in therapeutic targets
  - May focus more on behavioral strategies if cognitive dysfunction is significant
  - May focus on cognitive restructuring if posttraumatic amnesia is significant
  - May become overwhelmed easily (important to tailor treatment)

# Concussion Education: Key To Success!

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- Patients, families, providers, military command, employers, teachers
- Early intervention with TBI education and positive expectations have a direct effect on recovery
- Reduces patient and family anxiety

# Conclusion

- More than 80 percent of TBIs that occur each year are classified as mTBI/concussion.
- More than 80 percent of all TBIs occur in the non-deployed setting (CONUS).
- Headache is the most common symptom of concussion.
- “The Big Four” TBI symptoms are sleep, headache, mood and cognitive deficits.
- Early intervention and patient education are proven to show faster recovery time
- It is important to provide management through a multidisciplinary approach.

# References

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# Thank you, questions?

- Submit questions via the Adobe Connect or Defense Connect Online question box located on the screen.
- The question box is monitored and questions will be forwarded to our presenter for response.
- We will respond to as many questions as time permits.



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# Save the Date

Next DCoE monthly webinar:

Understanding Changes to  
the Posttraumatic Stress  
Disorder and Acute Stress  
Disorder Diagnosis in DSM-5

Sept. 5, 2013  
1-2:30 p.m. (EDT)

***\*\*\*Registration will open on 8/27/13\*\*\****

September						
S	M	T	W	T	F	S
1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21
22	23	24	25	26	27	28
29	30					

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